Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Lewis, a resident at Peterborough Approved Premises, on 1 October 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

OGL

© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Steven Lewis died on 1 October 2019 of mixed drug toxicity at Peterborough Approved Premises. Mr Lewis was 31 years old. I offer my condolences to Mr Lewis's family and friends.

Mr Lewis initially arrived at Peterborough Approved Premises on 26 July 2019 but was recalled to HMP Peterborough for using illicit substances four weeks later. On 20 September, Mr Lewis was released from prison again and returned to Peterborough Approved Premises.

Mr Lewis had a history of significant substance misuse. I note that the risk of an overdose due to a reduced drug tolerance following his release was not covered at the approved premises' induction. However, the issue was discussed with him by substance misuse workers in prison and in the community and I am satisfied that staff at Peterborough Approved Premises could not reasonably have prevented his death.

I am concerned that opioid antidotes are not available to staff working in approved premises managed by the National Probation Service. Although this did not affect the outcome in Mr Lewis's case, we have recommended in several previous investigations that the National Probation Service should review its drugs strategy for approved premises, and I am concerned by the length of time this is taking. Urgent action is now required.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2020**

Contents

Summary

Events

1. On 26 July 2019, Mr Steven Lewis was released on licence from HMP Highpoint and was required to live at Peterborough Approved Premises (AP). On 21 August, Mr Lewis tested positive for illicit substances and AP staff found drug paraphernalia in his room. On 24 August, Mr Lewis was recalled to HMP Peterborough for 28 days for breaching his licence conditions.

2. On 20 September, a prison substance misuse recovery worker reviewed Mr Lewis before his release from prison and noted that he declined to be issued with naloxone (an antidote for opiate overdoses). Later that afternoon, Mr Lewis returned to Peterborough Approved Premises and a residential worker conducted an induction.

3. Probation records show that staff conducted four drug tests after Mr Lewis returned to the approved premises, the last on 30 September, and that they were all negative.

4. At 6.20pm on 1 October, Mr Lewis spoke to staff in the office and appeared in good spirits. He left the approved premises a short while afterwards and returned at 7.20pm, 20 minutes late for his curfew. A residential worker spoke to Mr Lewis and told us that he did not present as under the influence of drugs or alcohol. Several minutes later, Mr Lewis went to his room and shut the door behind him.

5. At 11.04pm, a residential worker opened Mr Lewis's door to conduct a welfare check and saw him lying face down underneath the window. He alerted his colleague, another residential worker, and they tried to get a response from Mr Lewis. At 11.05pm, one of the residential workers went to collect his mobile phone and called an ambulance. He returned to Mr Lewis's room 33 seconds later.

6. At 11.07pm, the residential worker left Mr Lewis's room to get a defibrillator and returned 45 seconds later. He initially had difficulty removing Mr Lewis's jumper but eventually managed to attach the defibrillator and start cardiopulmonary resuscitation (CPR). At 11.16pm, paramedics arrived and took over resuscitation efforts. A paramedic pronounced at 11.42pm that Mr Lewis had died.

7. A post-mortem examination found that Mr Lewis died of mixed drug toxicity.

Findings

8. Mr Lewis had a long history of substance misuse and was recalled to prison for using illicit substances. After he returned to the approved premises on 20 September, Mr Lewis displayed a positive attitude and provided four negative drug tests. We are satisfied that AP staff could not have reasonably predicted Mr Lewis's actions.

9. We are concerned that Mr Lewis's risk of overdose due to a reduced drug tolerance was not covered at the AP induction, although the issue was discussed with him by substance misuse workers in prison and the community.

10. Although it is unlikely that they would have changed the outcome for Mr Lewis, we found that opioid antagonists (antidotes), such as naloxone, are not available to staff at approved premises managed by the National Probation Service. In several previous investigations, we have recommended that the National Probation Service review its drug strategy for approved premises. The National Approved Premises Team told us in response that they are currently working on a revised strategy and plan to implement it over the course of 2020.

11. We are satisfied that probation staff acted promptly when they found Mr Lewis unresponsive and acted in accordance with ambulance service instructions.

12. Although both residential workers did not have a phone with them when they were checking the rooms, there was no significant delay in calling an ambulance.

Recommendations

- The National Probation Service should provide the Ombudsman with an assurance that a revised drug strategy, which includes the use of opioid antagonists, will be implemented by December 2020.
- The manager of Peterborough Approved Premises should ensure that staff are aware of their responsibility to discuss reduced tolerance to drugs and the increased risk of overdose with all residents at induction.

The Investigation Process

13. The investigator issued notices to staff and prisoners at Peterborough Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator visited Peterborough Approved Premises on 9 October 2019. He obtained copies of relevant extracts from Mr Lewis' records and interviewed one resident.

15. The investigator interviewed two members of staff by phone on 25 October and five members of staff at Peterborough Approved Premises on 18 November.

16. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. The Coroner gave us the results of the post-mortem examination. We have him a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Lewis's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Lewis's mother raised the following issues:

    - she said that living at an approved premises was not good for Mr Lewis as he was isolated and vulnerable; and
    - she wanted to know the process for notifying the next of kin of a resident's death as the Coroner's office broke the news of Mr Lewis's death to her daughter.

    We have addressed these issues in this report.

18. Mr Lewis's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan is annexed to this report.

Background Information

Peterborough Approved Premises

20. Approved premises (formerly known as probation or bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

21. The National Probation Service manages Peterborough Approved Premises. It has 27 single rooms and 2 double rooms. Breakfast, a main meal and supper are provided and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty 24-hours a day.

Previous deaths

22. Mr Lewis was the first resident to die at Peterborough Approved Premises since October 2017. There has been one death since, the cause of which has not yet been established and which we are currently investigating.

Key Events

23. On 13 March 2018, Mr Steven Lewis was remanded to HMP Bedford, charged with grievous bodily harm. He was subsequently sentenced to two years and nine months in prison on 17 August. On 7 September, he was moved to HMP Highpoint. Mr Lewis had a history of significant substance misuse and received ongoing support in prison.

24. On 26 July 2019, Mr Lewis was released on licence from Highpoint and was required to live at Peterborough Approved Premises. When he arrived a residential worker discussed his licence conditions and the approved premises' rules. She noted that Mr Lewis intended to register with a GP practice and required drug and alcohol testing twice a week. Mr Lewis had with him two types of medication: mirtazapine (for depression) and naltrexone (for opioid and alcohol dependence). Staff kept his medication in the office and he had to collect it daily.

25. On 30 July, Mr Lewis failed to attend Aspire, a community substance misuse service, for a release appointment. On 31 July, Mr Lewis's offender manager, spoke to him by phone. She recorded that he had not left prison with enough mirtazapine but had collected a prescription from a local GP. That evening, Mr Lewis tested positive for alcohol (90.59mg/100mg – the current UK drink drive limit is 35mg/100mg).

26. On 5 August, Mr Lewis's offender manager conducted an intensive supervision probation interview with Mr Lewis. (This is a form of community supervision used to increase the level of surveillance.) She also gave Mr Lewis a verbal warning for testing positive for alcohol and asked him to contact Aspire.

27. On 12 August, Mr Lewis told his offender manager that Aspire had offered him one-to-one relapse prevention sessions because he did not like being around active drug users. The offender manager subsequently contacted a criminal justice recovery coordinator from Aspire, who told her that Mr Lewis had not attended any appointments since his release from prison.

28. On 13 August, Mr Lewis told his offender manager that he had been to Aspire on 26 August and that he would go to their office to identify who he had spoken to. When he arrived at Aspire later that afternoon, he spoke to the criminal justice recovery coordinator and she arranged to visit him at the approved premises.

29. On 14 August, a community psychiatric nurse saw Mr Lewis for a planned session at the approved premises. She spoke to him about his drug use and he asked to go on subutex (used to treat opioid addiction) as he felt 'empty inside'. The nurse identified that Mr Lewis's mirtazapine had not been reviewed for some time and booked him a follow-up appointment for 28 August, to discuss the possibility of a GP review.

30. On 15 August, the criminal justice recovery coordinator visited Mr Lewis at the approved premises to conduct an initial substance misuse assessment. Mr Lewis told her that a prison doctor had planned to prescribe subutex but that he was given naltrexone instead. She explained that substitute opiates are only prescribed to active users and continued with the physical health aspect of the assessment.

31. On 21 August, Mr Lewis tested positive for several illicit substances including, opiates, cocaine and cannabis. Staff subsequently searched his room and found drug paraphernalia. On 22 August, Mr Lewis' keyworker, gave him a warning letter for breaking the approved premises' rules. Later that day, the approved premises manager, and the area manager, decided to withdraw Mr Lewis's placement.

32. On 24 August, Mr Lewis was recalled to HMP Peterborough for 28 days for breaching his licence conditions. At an initial health screen, a nurse noted that he had a history of illicit drug use and referred him to the prison's substance misuse team. A locum GP reviewed Mr Lewis and recorded that his urine tested positive for subutex, opiates, cocaine and benzodiazepines (used to treat seizures and anxiety). She prescribed several medications, including metoclopramide (used to treat acid reflux) and chlordiazepoxide (used to treat anxiety and alcohol withdrawal).

33. On 25 August, a healthcare assistant, reviewed Mr Lewis and created a substance misuse care plan. On 2 September, a substance misuse recovery worker, noted that Mr Lewis had declined a naloxone pack (an emergency antidote for overdoses caused by heroin and other opiates).

34. On 10 September, Mr Lewis's offender manager noted that Mr Lewis had asked if he could return to Peterborough Approved Premises after his release from prison as he had registered with a GP, the job centre and Aspire. She subsequently contacted the approved premises' manager who confirmed that Mr Lewis could return there.

35. On 19 September, the criminal justice recovery coordinator reviewed Mr Lewis at HMP Peterborough. She told the investigator that Mr Lewis appeared motivated and spoke a lot about positive change. She told him about the risk of overdose due to a reduced drug tolerance and arranged for him to attend a welcome session at Aspire.

36. On 20 September, a nurse reviewed Mr Lewis before his release. She noted that he did not report any healthcare concerns and had his prescribed medication to take with him. A substance misuse recovery worker reviewed Mr Lewis and noted that he declined naloxone as he felt it would be a trigger. At 8.46am, he was released from HMP Peterborough.

37. Mr Lewis arrived at Peterborough Approved Premises at 1.55pm. He told a residential worker that he had an appointment with Aspire at 2.00pm and left. He returned at 2.35pm, and told him that he did not arrive earlier as his licence said that he had to report at 2.00pm. The residential worker went through the conditions of Mr Lewis's licence and the approved premises rules. He noted that Mr Lewis required drug testing twice a week and alcohol testing three times a week. There is no record that he spoke to him about his reduced tolerance to drugs.

38. On 26 September, the criminal justice recovery coordinator visited Mr Lewis at the approved premises and noted that he presented very well and said that he had only used drugs once since his release from prison. On 27 September, Mr Lewis's appointed keyworker met him to explain her role. She recorded that he

had seen the criminal justice recovery coordinator and that the last time he took illicit substances was before he was recalled to prison.

39. Probation records show that staff conducted four drug and alcohol tests after Mr Lewis's return to the approved premises. The last of the tests took place on 30 September and they were all negative. A resident who knew Mr Lewis told the investigator that Mr Lewis used to go to him after he had used drugs, 'full of remorse'. He said that Mr Lewis knew what he had to do to overcome his substance misuse issues but found it difficult.

Events on Tuesday 1 October

40. At 12.00 noon on 1 October, residential worker conducted the residents' welfare checks. However, there is no written record to show they took place. In his statement for the Probation Service, he said that he could not remember seeing Mr Lewis in his room.

41. A residential worker conducted the 6.00pm welfare checks and also failed to record that she had completed them. In her statement for the Probation Service, she said that she could not remember seeing Mr Lewis in his room. At 6.20pm, Mr Lewis went into the office and offered biscuits to her and another residential worker. The residential worker told the investigator that Mr Lewis seemed in good spirits and did not present as under the influence of illicit substances.

42. A short while afterwards, Mr Lewis left the approved premises. At 7.05pm, five minutes after his curfew, he contacted a residential worker and said he was on his way back. Mr Lewis arrived at around 7.20pm and told him that he had gone to the shop. The residential worker told us that Mr Lewis did not appear under the influence of illicit substances or display any signs of concern. Around two minutes later, CCTV footage shows that Mr Lewis went into his room and shut the door behind him. At 7.58pm, CCTV shows that a resident knocked on Mr Lewis's door and waited a few seconds before walking off.

43. At 11.04pm, a residential worker opened Mr Lewis's door to conduct a welfare check and saw him face down on his knees between a radiator and a chest of drawers. He alerted another residential worker who looked at Mr Lewis and went promptly to the office to call an ambulance. CCTV shows that he left the room at 11.05pm and returned 33 seconds later. The ambulance service record shows that they received a call requesting an ambulance at 11.06pm.

44. Both residential workers approached Mr Lewis and noticed that his hands were blue and that his face was bleeding. They also noticed a spoon containing what looked like heroin on the chest of drawers. At 11.07pm, a resident support worker left the room to get a defibrillator and returned 45 seconds later. In the meantime, the other residential worker turned Mr Lewis over and laid him on the floor. The residential worker who collected the defibrillator told the investigator that he tried to attach the device, but Mr Lewis's body was so stiff that he had difficulty removing his jumper. He said he eventually managed to attach the defibrillator and start cardiopulmonary resuscitation (CPR), as directed by the ambulance service operator.

45. At 11.16pm, paramedics arrived at Mr Lewis's room and took over resuscitation efforts. At around 11.20pm, residential support worker B contacted the on-call manager, and she arrived a short while afterwards. At 11.42pm, a paramedic pronounced that Mr Lewis had died.

Contact with Mr Lewis's family

46. The on-call manager told the investigator that police officers present requested Mr Lewis's next of kin details so that they could inform them of his death. She said that they gave the police Mr Lewis's sister's address in Hertfordshire as he had named her as his next of kin. She said that the police told her that they would contact Hertfordshire police and ask if they could break the news of Mr Lewis's death to his sister. (The normal practice when a resident dies in an approved premises is for the police to inform the next of kin.)

47. At around 2.15pm on 2 October, the area manager contacted the police to find out if they had spoken to Mr Lewis's family as his mother had received a call from the Coroner's office and phoned the North Hertfordshire probation team, asking for information. The police confirmed that they had spoken to Mr Lewis's mother and he contacted her by phone to offer his condolences and support later that day.

48. The area manager continued to provide ongoing support to Mr Lewis's mother until his funeral, which he attended, on 21 October. The probation service offered to contribute towards the cost, in line with national policy.

Support for prisoners and staff

49. After Mr Lewis's death, the on-call offered immediate support to the staff on duty. The area manger offered support to all the staff who worked at the approved premises when he arrived later that morning.

50. Staff held a meeting and told all the residents that Mr Lewis had died and offered support. Notices were posted.

Post-mortem report

51. The post-mortem report identified moderate levels of alcohol and potentially fatal levels of morphine (heroin) in Mr Lewis's blood. Cocaine and therapeutic levels of pregabalin (a painkiller) and mirtazapine were also detected. The report noted that opiate toxicity and moderate alcohol levels can result in respiratory depression and that cocaine use can cause abnormal heart rhythms. It concluded that Mr Lewis died of mixed drug toxicity.

Findings

Substance misuse

52. Mr Lewis had a significant history of substance misuse. The risk of relapse for a released prisoner with a history of substance misuse is high, especially for someone like Mr Lewis who had been recalled to prison for using drugs. Opioid dependence is a chronic disorder with a high relapse rate, even after prolonged periods of abstinence and a positive mindset. The risk of fatal overdose is also high as after a period of abstinence, opiate users are particularly vulnerable due to a diminished tolerance, especially in the immediate post-release period.

53. The Approved Premises Manual 2014 states that reduced drug tolerance should always be covered at induction. We are concerned that the induction paperwork signed by Mr Lewis did not have a specific section on reduced tolerance and that a residential worker did not cover this issue on 20 September. The residential worker told the investigator that he did not discuss reduced drug tolerance with him as he is "not all that trained" and that "Aspire would discuss that with him".

54. In response to a PPO investigation in October 2019, the National Approved Premises Team issued a revised version of the nationally-used induction template with a section on reduced drug tolerance. While we are satisfied that a new template is now in use, we are concerned that the residential worker was not aware of the requirement to discuss this risk at induction. We therefore make the following recommendation:

    The manager of Peterborough Approved Premises should ensure that staff are aware of their responsibility to discuss reduced tolerance to drugs and the increased risk of overdose with all residents at induction.

55. The post-mortem report established the cause of Mr Lewis's death as mixed drug toxicity. Although Mr Lewis had been recalled to prison for using drugs and told the criminal justice recovery coordinator that he had used drugs once since his release on 20 September, he told his appointed keyworker that the last time he took drugs was before he was recalled. Probation records show that he was apologetic about his previous behaviour and displayed a positive attitude towards change. He also provided four negative drug tests after his release, the last of these on 30 September.

56. The staff, including the residential worker who had contact with Mr Lewis when he returned late on 1 October said that he seemed normal and did not present as under the influence of drugs. We are satisfied that they did not have sufficient reason to suspect that he may be using drugs or to conduct a drug test. We do not consider that staff could reasonably have prevented his death.

57. However, we are concerned that staff in approved premises, which hold a particularly high-risk group of people, are apparently ill-equipped to respond to drug overdoses. In November 2014, the World Health Organisation launched new guidelines on the management of heroin overdoses in the community which recommended training first responders, including non-medical first responders, to administer opiate antagonists (antidotes), such as naloxone.

58. Historically, opioid antagonists were used only by clinicians but are now being provided to drug users, their families and other potential first responders who may not be clinically trained. Given the potentially lifesaving properties of opioid antagonists, we are concerned that opioid antagonists are not available to staff in approved premises managed by the National Probation Service (although some approved premises residents may have them on a personal basis). While we recognise that staff having access to naloxone is unlikely to have changed the outcome in Mr Lewis's case, it could be critical in other emergencies.

59. In several investigations dating back to 2016, we have recommended that the National Probation Service review its drugs strategy for approved premises. The Deputy Head of the National Approved Premises Team, told us that a substance misuse subgroup is currently working on a revised strategy, which will include the use of opioid antagonists. She said that after a period of consultation and liaison, they aim to roll out the strategy nationally over the course of 2020. While this is encouraging, we are concerned that this strategy has been in the development stage for a significant period and consider that urgent action is needed to ensure it is implemented at the earliest opportunity. We make the following recommendation:

The National Probation Service should provide the Ombudsman with an assurance that a revised drug strategy, which includes the use of opioid antagonists, will be implemented by December 2020.

Emergency response

60. Although both residential workers did not have a phone with them when they were checking the rooms, there was no significant delay in calling an ambulance.

61. The residential worker who obtained a defibrillator noticed that Mr Lewis's body was stiff when he assessed him which would indicate that rigor mortis was present, meaning that he had died some time before he was found. Resuscitation would not generally be considered appropriate in such circumstances but we recognise that he was not clinically trained and acted on the instructions of the ambulance service operator. We note also that paramedics continued the resuscitation effort when they arrived. We therefore do not make a recommendation in this case.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141